

the next 12 months will be keeping consumers aware that all their expectations can't be met. People need to understand that the world can't change overnight. This is a method of doing it slowly through the system, rather than banging heads together to get quick responses which doesn't re-

ally create long term change." This statement is still relevant today. Attitudinal, long term change takes time. My office has been the focus of an enormous amount of expectation from individuals, interest groups and the media, both in terms of the issues I am able to address and the time and

resources it should take me to do so. Despite this pressure, the legislation is successfully fulfilling the legacy of the Cartwright inquiry - transforming individual tragedy into systemic change to ensure mistakes are not repeated and the lessons benefit all.

## Article

### Virtuous Doctors or Virtuous Patients?

Alastair Campbell

Centre for Ethics in Medicine, University of Bristol

My title is deliberately provocative, and will at once raise questions in your minds about my sense of proportion. Isn't 'virtue' a very elitist word, suggesting somewhat smug people, who see themselves a cut above the ordinary mortal? And why expect doctors to be 'virtuous'? Isn't it enough that they are dutiful, conscientious in their care of patients? Even worse, how dare we impose the demand to be virtuous on the sick - isn't it hard enough just to be a patient, without having to be a virtuous one as well?

These questions are understandable reactions, but they represent a misunderstanding of the place of virtue in moral theory, and so in medical ethics. By paying attention to virtue we are shifting our attention from questions of right action to questions of enduring human character. Modern moral philosophy, influenced by the Judaeo-Christian tradition, has focused on the question: How should I act? But Virtue Ethics, in both its ancient and its modern forms, seeks answers to a different question: How should I *live*? In answering this latter question, virtue ethics has to describe specific human excellencies of character or behaviour to which individuals or social groups should aspire.

The modern revival of interest in such questions may be traced to Alasdair MacIntyre's *After Virtue* (1984). In this work MacIntyre argued that the post-Enlightenment project of achieving moral agreement through a shared set of rational principles is a manifest failure. Our supposed rationality is itself socially and historically determined and the liberal ideal of toleration,

rather than achieving consensus, has merely revealed the incompatible diversities of the modern age. As a result, what were formerly prized for themselves as human goods (for example, the seeking of knowledge for its own sake, or the practice of a craft for its inherent satisfaction) are now regarded as of value only if they bring results in market value terms, only if they have extrinsic value. It is unclear whether MacIntyre believes that a return to virtue is possible, but if it is to be achieved, then it has to be within the context of *practices*, which are shared human activities of acknowledged internal value. MacIntyre defines practices as:

... any coherent and complex form of socially established human activity through which goods integral to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.<sup>1</sup>

Clearly, medicine may be seen as a 'practice' in this sense, and so one concern of medical ethics must be not just the *rightness* of medical decisions but the success or failure of modern medicine in enabling both doctors and patients to share in a common endeavour, which they both regard as of intrinsic value, as a fulfilment of themselves and of their aspirations in life. Another way we can express this is to use MacIntyre's term 'the narrative unity of human life'. Do the encounters between patients and health care professionals contribute to that sense

of continuity of lives of inherent worth? If not, then what needs to change in the ethos of health care to enable this to happen, at least some of the time?

#### Dangerous Myths

To consider this key question let us consider the dangerous myths about virtue that have clung to the delivery of health care for generations. These are myths both about what makes a 'good' doctor and what makes a 'good' patient.

#### *The Doctor as God*

The first myth is created by the fears which illness provokes. Faced with the uncertainties of human pain and fragility, doctors and patients alike are tempted to endue the profession with a godlike presence, an appearance of virtue which can shield them both from anxiety. We see this myth in the nineteenth-century admonition of the AMA about the appropriate bedside manner:

A physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission. Physicians should, therefore, minister to the sick with due impressions of the importance of their office. They should study, also, in their deportment, so to unite tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence.<sup>2</sup>

and it is wonderfully portrayed in Tolstoy's *The Death of Ivan Illych*:

... from the doctor's summing up Ivan Illych concluded that things looked bad,

but that for the doctor, and most likely for everybody else, it was a matter of indifference, though for him it was bad. And this conclusion struck him painfully, arousing in him a great feeling of pity for himself, and of bitterness towards the doctor who could be unconcerned about a matter of such importance.

But he said nothing. He rose, placed the doctor's fee on the table and remarked with a sigh, 'We sick people no doubt often put inappropriate questions. But tell me, in general, is this complaint dangerous or not?'

The doctor regarded him sternly over his spectacles with one eye, as though to say, 'Prisoner at the bar, if you will not keep to the questions put to you, I shall be obliged to have you removed from the court.'

'I have already told you what I consider necessary and proper,' said the doctor. 'The analysis may show something more.' And the doctor bowed.

Traditional medical oaths also have the effect of sanctifying the profession (the Hippocratic Oath speaks of 'purity and holiness', but of course that group of ancient doctors were almost certainly bound by a form of religious allegiance). In our more cynical age, the realities of medical practice have been conveyed by a caricature of Hippocrates. For example, the original admonition to keep secrets quoted below is given a dose of reality in the spoof version that follows:

What I shall see or hear in the course of the treatment or even outside of the treatment in regard to the life of men which on no account must be spread abroad, I will keep to myself, holding such things shameful to be spoken about.

*Things I may see or hear in the course of treatment or even outside treatment regarding the life of human beings – things that one should never divulge outside – I will report to Government commissions or administrators, or will use in my book.*

But even better for my purposes is the cynical rewrite of the admonition to keep patients from harm:

I will apply dietetic measures for the benefit of the sick according to my ability and judgement. I will keep them from harm and injustice.

*I will apply dietetic measures for the benefit of the obese, the alcoholic, the smoker, and the drug addict, but because these days everyone has the right to do his or her own thing, I will seldom be able to keep them from self-harm and injustice.*

## The Compliant Patient

Matching the myth of the godlike doctor whose virtue saves the patient from harm is the traditional account of the virtues of patienthood. Karen Lebacqz has neatly described this mythical figure. In our culture, '... the sick person is expected to submit to the techniques and facilities of medical science, to cooperate with his physician, and in this way do everything he can to facilitate his recovery.' As one commentator puts it, 'The patient's role was to accept treatment, make payments, and not to ask questions.' Such a view of virtuous patienthood is of course very ancient, and crosses many cultures. Here, for example, is how the Stoic philosopher Epictetus instructs the reader on the way a philosopher will bear illness:

Not to blame either God or man, not to be distressed at what happens; to await death in a right and becoming manner, and to do what you are bidden. When the physician enters, not to be afraid of what he may say; nor if he should tell you are in a fair way, to rejoice overmuch.... (The Discourses of Epictetus, Chapter 10)

No doubt such acceptance of death and stoicism in the face of illness have much to commend them, but to equate this with the virtues of patienthood is, I believe, a mistake, for it makes the patient a passive recipient of medical news, and a mere spectator of the drama of his or her own battle with ill-health.

In place of these dangerous myths about the doctor-patient relationship I want to suggest a view of virtue that sees it in more active (though realistic) terms. Especially I want to look for ways in which acting virtuously as a patient involves incorporating the threat of illness into one's quest for the goodness of being human, and of a virtue in doctoring that enables this quest to take place. In stark contrast to the stoic and passive account of bearing suffering just described, my approach is informed instead by these words from Rene Dubos' classic work, *The Mirage of Health*:

While it may be comforting to imagine a life free of stresses and strains in a carefree world, this will remain an idle dream. Man cannot hope to find another paradise on earth, because paradise is a static concept while human life is a dynamic process ... The earth is not a resting place. Man has elected to fight, not necessarily for himself but for a process of emotional, intellectual and ethical growth that goes on for ever. To

grow in the midst of dangers is the fate of the human race ...<sup>3</sup>

## The Practical Virtues

What then might this all mean amid the practicalities of modern medical care? We need a whole new literature about ethics, one which is yet to be written. Too much of the literature has focused on the dilemmas of acute medicine, giving the false impression that most of medicine proceeds through dramatic decision-making in life or death situations. In fact, for the vast majority of patients, the issues are ongoing ones, with no obvious resolution through a single decision. There are of course wonderfully effective life-saving interventions, and we are very fortunate compared with the time when the Stoics wrote, when illness meant almost certain death sooner or later. But modern medicine, for all its successes, leaves us still with the enduring human condition of fragility and finitude, and although much can be done to avert early death, life is (as one wit put it) 'a sexually transmitted terminal illness'. The question is, what can medicine do in that journey from birth to death to enable health, in the dynamic sense described by Dubos? This is the challenge that virtue ethics seeks to meet. To answer this in a practical way I shall consider two cases, which I believe illustrate how the interaction between patients and health care professionals can either enable or frustrate the 'narrative quest' of both parties. The first patient, whom I have called Miriam, is my negative example:

Miriam, a single woman in her late twenties, kept being referred to a medical ward of a large academic hospital for tests to establish the cause of her very severe gastric problems. Cancer of the stomach had been suspected, but an exhaustive range of investigations and tests revealed nothing. Eventually the professor began to suspect that her symptoms were self-induced by means of frequent heavy use of purgative drugs. He instructed the nursing staff to persuade her to leave the ward on a false pretext, and during her absence to search her possessions. Sure enough, the search revealed a large quantity of the relevant medicine. He then confronted Miriam with this discovery, accusing her of wasting his time and urging her to seek psychiatric help for her obsessive need to gain attention through illness. Miriam angrily denied that she used such drugs, claimed (quite rightly) that the

hospital had invaded her privacy, and discharged herself in great distress.

This extreme example illustrates a fundamental point about the responsibility promoted by virtue ethics. It is a commitment to value which comes from within, and it cannot be imposed by external authority, nor can a person be manipulated in taking responsibility. The professor failed lamentably to provide medical care to Miriam, because he refused to treat her self-induced illness with any sense of respect for his patient. In trying to impose on her his idea of responsible behaviour he merely drove her away from any access to a care which could have discovered the origins of her overwhelming need to be ill. We cannot make people into models of virtue according to our conception of the good patient!

My second case example, illustrates what can happen when the doctor remains 'offstage', offering skilled advice, but allowing the patient to find her own solution to an ongoing dilemma in her life choices:

Deborah had suffered from diabetes since early childhood. She was now in her late twenties and happily married to Don. Don's job brought in a good salary and Deborah was able to stay at home, looking after their pets and pursuing her interest in art. She was an accomplished water colourist, with several of her paintings on sale in art shops in the city. Her diabetes was very difficult to control and she was house bound much of the time. Her characteristic painting style was views from inside to the outside, framed by windows.

Deborah and her husband fervently wished to start a family, Deborah believing she could cope as mother, despite her vulnerable condition, especially since her parents lived nearby and already helped a great deal. Unfortunately, pregnancy proved to be very dangerous for her. Despite skilled obstetric support, her blood sugar balance went wildly out of control each time she became pregnant, and on several occasions her husband came home to find her in an insulin coma. After three attempts at continuing a pregnancy to full term, each one ending with a termination because of the severe hazard to her life, Deborah was advised by her obstetrician to avoid further conceptions, either by an effective and safe contraceptive method (not easy to find in her case) or by sterilization. After agonizing over the decision for some time and talking it through with Don and her parents, Deborah decided that

she should be sterilized by tubal ligation. She consoled herself with the thought that this was not as radical and risky as hysterectomy and was (in theory) reversible, should her diabetes settle a bit in the next few years. But these consolations, she realized, were to some extent an escape from the reality that she would almost certainly never experience childbirth and motherhood. 'Our dogs and cats will have to be my baby substitutes', she said, 'and I will produce as my offspring pictures that offer something of mine to the world.' She reconsidered her creativity and her talent for painting, wondering if she dared move away from the style that always portrayed the world as outside, enclosed by a window frame.

Deborah's story takes us into some of the universal spheres of human experience, spheres which must surely be strong candidates for a specification of the virtues required to live well. Firstly, she was experiencing her own generativity, both as an artist and as a potential mother. Creativity, whether through parenthood or through artistic or technological innovations, is a powerful source of human fulfilment, as well as of pain and frustration.

Learning to express one's creativity, to contribute something other than oneself to the sum total of the world, is clearly important to all humans, as the earliest manifestations of artistic culture in human societies demonstrate. The unhappiness of the infertile testifies to the potency of this urge to create, even though social conditions and expectations can also either exaggerate or diminish it. For Deborah the urge to create was severely compromised by her medical condition. Childbirth apart, the severity of her illness affected her art also, leading to the powerful symbol of the window frame in all her pictures of the world. Here again we are into some basic aspects of human experience, since it is a feature live with frustration and, with at least temporary failure of our cherished plans, is part of what it is to be human and our responses to such setbacks are an important component of what we call virtue.

In addition, Deborah had to consider at an early age what is perhaps the most fundamental of all human experiences, the awareness of our own mortality. She was faced with a stark choice between birth and very likely death, and she had to ask basic questions about her moral duty as a woman who could give birth to a child who would immediately be left with-

out her care. Her choice, after much agonized deliberation, was to express her generativity in a new style of less constricted paintings, and to satisfy her need to care for a dependent creature in care of her pets. Her answer to 'How should I live?' seems to have been that she should live in a way that fulfils herself but at the same time cares for those close to her. She could not choose to be a woman who fulfils her profound desire for a baby at the likely cost of grief to that child and to her husband and parents. She sought a solution which held together all that she cherished in life, within the constraints imposed upon her by her illness.

## Conclusion

This article has attempted to sketch an outline of the virtues that might make medical encounters into fulfilling acts for both doctors and patients alike. I am acutely aware of the dangers of unreality and unhelpful idealism in what I have been suggesting. It is not easy to get the subtle balance between active involvement and helpful detachment in professional relationships right. Often, patients themselves have no interest in the kind of struggle for fulfilment through difficulty that I have been describing, and just want a 'quick fix'. We live in a fix-it age, in which the latest pill crazes of Viagra and Prozac are obvious examples. No wonder doctors look for a technology that will keep their patients reasonably happy while making them a good income and avoiding too many sleepless nights. Yet reality tells us also that we have escalating problems of ill-health related to a discontent for which there is no technical fix, and for the health care professions, the reality is mounting levels of stress, and frightening statistics of alcohol and drug abuse, and the ever present high suicide rate. It may be difficult to do, but I think patients and their professional carers both desperately need to rediscover a shared commitment to health in the midst of danger, one which can restore a sense of a life worth living and a life well lived.

## References

- 1 Alasdair MacIntyre (1984) *After Virtue*, University of Notre Dame Press, Indianapolis, p. 187.
- 2 Chauncey D. Leake (1975) *Percival's Medical Ethics*, Krieger, New York.
- 3 Rene Dubos (1979) *The Mirage of Health*, Harper & Row, New York, p. 221.